South Carolina Healthy Connections
PO Box 100101
Columbia, SC 29202
(888) 549-0820

Date:
BG#:
HH#:
Case Name:

South Carolina Medicaid Program

Annual Review Form

This form is used to review your Medicaid Coverage

You must return this form to us by:

Return to: SCDHHS-Central Mail, PO Box 100101, Columbia, SC 29202

- If you do not return this form, your Medicaid will stop.
- If you do not return proof of your income, we cannot continue your Medicaid.
- Please fill out EACH item on this form.
- If an item does not apply, write “does not apply”
- If an answer to any question is none or 0, write “none”

If you need help filling out this form, call Healthy Connections at (888) 549-0820.
Si necesita ayuda para llenar este formulario, puede llamar.

STEP 1

What language do you use most? ☐ English ☐ Spanish ☐ Other (specify)

Fill out the following information about yourself:

Last Name	**First Name**			**Middle Initial**
Mailing Address (include Apartment / Lot Number)	**City**	**County**	**State**	**Zip Code**
Street Address if different (include Apartment / Lot Number)	**City**	**County**	**State**	**Zip Code**
Telephone Number where we can reach you including area code **Phone # ( )** **Second Phone # ( )** **Email address:**				**FOR AGENCY USE** Date Received:

STEP 2

Give us the name of any family members who have moved OUT of your home in the past year.

Full Name	Date of Birth (mm/dd/yyyy)	Gender

If an Authorized Representative is completing this application, please complete the following:

Name: _____ Address: _____ Phone: _____

American Indian or Alaska Native (AI/AN) family member(s)
Are you or is anyone in your family American Indian or Alaska Native?
☐ No. If no, skip to next section ☐ Yes. If yes, please complete the section below.

Answer the following questions to make sure your family gets the most help possible.

	AI/AN Person 1	AI/AN Person 2
	Name:	Name:
Member of a federally recognized tribe?	☐ Yes ☐ No If Yes, tribe name:	☐ Yes ☐ No If Yes, tribe name:
Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If No, is this person eligible to get services from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from one of these programs? ☐ Yes ☐ No
Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your review that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties • Payments from natural resources, farming, ranching, fishing, leases or royalties from land designed as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often? _____	$ _____ How often? _____

STEP 3

Tell us about your family. Start with yourself.

Name (First, Middle Initial, Last)	Relationship to Person 1	Date of Birth	Gender	Social Security Number
	SELF			

Additional Information

1. Do you plan to file a federal income tax return next year? ☐ Yes ☐ 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, name of dependents: _____
      _____
   c. Will you be claimed as a dependant on someone else's tax return? ☐ Yes ☐ No
      If YES, list name of the tax filer: _____
      How are you related to the tax filer: _____

2. Are you pregnant or were you recently pregnant? ☐ Yes ☐ No
   How many babies are expected? _____
   What is your due date? _____
   If recently pregnant, enter the date the pregnancy ended: _____
   Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

3. Do you need health coverage (Medicaid)? if NO, skip to Question 5. ☐ Yes ☐ No
   (Even if you have insurance, there might be a program with better coverage or lower costs.)
   a. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
   b. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
   c. 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)
   d. 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.

   e. Are you a full-time student? ☐ Yes ☐ No
   f. Were you in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

4. If Hispanic/Latino, ethnicity (OPTIONAL-Check all that apply)

   ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

   Race (OPTIONAL-Check all that apply)

   ☐ White ☐ Asian Indian ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Other Pacific Islander

   ☐ Black/ African American ☐ Japanese ☐ Other Asian ☐ Samoan ☐ Chinese ☐ Korean ☐ Other: _____

Current Job and Income Information

5. Employed ☐ *Start with Question 6.* Self-Employed ☐ *Skip to Question 8.* Not Employed ☐ *Skip to Question 9.*

6. **Employer 1** Name and Address _____ Employer Phone _____ Start Date _____ Average hours worked each week _____

Wages/tips (before taxes) / Paid
$ _____ / ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Employer 2 Name and Address _____ Employer Phone _____ Start Date _____ Average hours worked each week _____

Wages/tips (before taxes) / Paid
$ _____ / ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

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

8. If self-employed: Type of work: _____ How much net income will you get from this self-employment this month? $ _____

9. 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 Accts $_____ How often? _____ ☐ Type: _____ $ _____ How often? _____
☐ Alimony received $_____ How often? _____ ☐ Type: _____ $ _____ How often? _____

10. Deductions: *Check all that apply and give the amount and how often you get it. NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.*

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

11. Yearly Income: *Complete only if your income changes from month to month. If you don't expect changes to your monthly income, you may add another person on the following pages, if needed.*

Your total income this year: $ _____ Your total income next year (if you think it will be different): $ _____

Tell us about household members enrolled in your Medicaid plan.
If you need to add multiple people, make copies of the next two blank pages (for each person) before proceeding.

Name (First, Middle Initial, Last)	Relationship to Person 1	Date of Birth	Gender	Social Security Number

Additional Information

1. Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If no, skip to question c.

   a. Filing jointly with a spouse? ☐ Yes ☐ No
   if YES, name of spouse: _____

   b. Claiming any dependents on tax return? ☐ Yes ☐ No
   if YES, name of dependents: _____
   _____

   c. Claimed as a dependant on someone else's tax return? ☐ Yes ☐ No
   If YES, list name of the tax filer: _____
   How are you related to the tax filer: _____

2. Is this person pregnant or recently pregnant? ☐ Yes ☐ No
   How many babies are expected? _____
   What is your due date? _____
   If recently pregnant, enter the date the pregnancy ended: _____
   Enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

3. Does this person need health coverage (Medicaid)? if NO, skip to Question 5. ☐ Yes ☐ No
   (Even if you have insurance, there might be a program with better coverage or lower costs.)

   a. Does this person have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No

   b. Does this person need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

   c. Has this person 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)

   d. Do this person 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.

   e. Is this person a full-time student? ☐ Yes ☐ No

   f. Was this person in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

4. If Hispanic/Latino, ethnicity (OPTIONAL-Check all that apply)
   ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other
   Race (OPTIONAL-Check all that apply)
   ☐ White ☐ Asian Indian ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Other Pacific Islander
   ☐ Black/ African American ☐ Japanese ☐ Other Asian ☐ Samoan ☐ Chinese ☐ Korean ☐ Other: _____

Current Job and Income Information

5. Employed ☐ *Start with Question 6.* Self-Employed ☐ *Skip to Question 8.* Not Employed ☐ *Skip to Question 9.*

6. **Employer 1** Name and Address _____ Employer Phone _____ Start Date _____ Average hours worked each week _____

Wages/tips (before taxes) / Paid
$ _____ / ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Employer 2 Name and Address _____ Employer Phone _____ Start Date _____ Average hours worked each week _____

Wages/tips (before taxes) / Paid
$ _____ / ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

7. In the past year, did this person: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

8. If self-employed: Type of work: _____ How much net income will person get from this self-employment this month? $ _____

9. 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? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement Accts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental /royalty $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

10. Deductions: *Check all that apply and give the amount and how often you get it. NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.*

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

11. Yearly Income: *Complete only if your income changes from month to month.*

Your total income this year: $ _____ Your total income next year (if you think it will be different): $ _____

New Household Member ***If you have a new person in your household who is not enrolled in your Medicaid plan, you may complete this section to see if they qualify for Medicaid. If you have more than one person, make blank copies of this section to add them.***

Name (First, Middle Initial, Last)	Relationship to Person 1	Date of Birth	Gender	Social Security Number
Address, if different from Person 1:	If no SSN, has this person applied for one? ☐ Yes ☐ No			

Additional Information

1. Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No

   a. Will this person file jointly with a spouse? ☐ Yes ☐ No
   if YES, name of spouse: _____

   b. Will this person claim any dependents on his/her tax return? ☐ Yes ☐ No
   if YES, name of dependents: _____

   c. Will this person be claimed as a dependant on someone else's tax return? ☐ Yes ☐ No
   If YES, list name of the tax filer: _____

   How is this person related to the tax filer: _____

2. Is this person pregnant or recently pregnant? ☐ Yes ☐ No
   a. How many babies are expected? _____
   b. What is your due date? _____
   c. If recently pregnant, enter the date the pregnancy ended: _____
   d. Was this person enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

3. Does this person need health coverage (Medicaid)? if NO, skip to Question 13. ☐ Yes ☐ No
   (Even if you have insurance, there might be a program with better coverage or lower costs.)

   a. Does this person have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No

   b. Does this person need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

   c. Has this person 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)

   d. Do this person want to apply for Family Planning benefits? ☐ Yes ☐ No

4. a. Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

   b. If this person isn't a U.S. citizen or U.S. national, does this person have eligible immigration status? ☐ Yes ☐ No

   If this person has eligible immigration status, fill in the document type and ID number below:
   c. Immigration document type: _____ d. Document ID number: _____

   e. Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

   f. Is this person, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

5. If this person has not applied for a Social Security Number, check the reason(s)

   ☐ 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

6. Does this person 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 $_____

7. Does this person live with at least one child under 19, and is the main person taking care of this child? ☐ Yes ☐ No
8. Is this person a full time student? ☐ Yes ☐ No

9. Was this person in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No
10. Is this person currently living in a foster home? ☐ Yes ☐ No
11. Is this person currently living in a DJJ group home? ☐ Yes ☐ No

12. If Hispanic/Latino, ethnicity (OPTIONAL-Check all that apply)

☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Race (OPTIONAL-Check all that apply)

☐ White ☐ Asian Indian ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Other Pacific Islander

☐ Black/ African American ☐ Japanese ☐ Other Asian ☐ Samoan ☐ Chinese ☐ Korean ☐ Other: _____

Current Job and Income Information

13. Employed ☐ *Start with Question 14.* Self-Employed ☐ *Skip to Question 16.* Not Employed ☐ *Skip to Question 17.*

14. **Employer 1** Name and Address _____ Employer Phone _____ Start Date _____ Average hours worked each week _____

Wages/tips (before taxes) / Paid
$ _____ / ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Employer 2 Name and Address _____ Employer Phone _____ Start Date _____ Average hours worked each week _____

Wages/tips (before taxes) / Paid
$ _____ / ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

15. In the past year, did this person: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

16. If self-employed: Type of work: _____ How much net income will person get from this self-employment this month? $ _____

17. 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 Accts $_____ How often? _____ ☐ Type: _____ $ _____ How often? _____

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

18. Deductions: *Check all that apply and give the amount and how often you get it. NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.*

☐ Alimony paid $_____ How often? _____ ☐ Other deductions: ☐ Type: _____ $ _____ How often? _____

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

19. Yearly Income: *Complete only if your income changes from month to month.*

Your total income this year: $ _____ Your total income next year (if you think it will be different): $ _____

STEP 4 - **Your Family's Health Coverage**

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

Policy Holder	List everyone covered by this insurance	Name of insurance company	Policy number / Medicaid number

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 contacting SCDHHS at (888) 808-4238 (TTY 888-842-3620) and filing a written Civil Rights Discrimination Complaint with the Civil Rights Division, SCDHHS, PO 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.

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 review have a parent living outside of the home? ☐ Yes ☐ No

I confirm that no one applying for health insurance on this review 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 for tax returns to renew my coverage

Signature (if applicable) The person listed in Step 1 does not need to sign the review since we already have a signature on file. If a newly appointed authorized representative completed the review, he or she 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 review.

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

_____ _____

Mail the completed review to: SCDHHS Central Mail, PO Box 10010, Columbia SC 29202-3101

State agency offices can also help you register to **vote**. If you want to **register to vote**, you can complete a voter registration form at scvotes.org, call the South Carolina Halthy Connections Member Contact Center at (888) 549-0820 or visit your local county SCDHHS office if you would like us to assist you with registering to vote.

Please return your completed form within 30 days of the Date listed on Page 1.