SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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June 1, 2018

MEDICAID ALERT

TO: **All Providers**

SUBJECT: **Beneficiary Eligibility Impacts for June 2018**

The Code of Federal Regulations (42 CFR 435.916) requires the state Medicaid agency to implement streamlined annual renewal processes for Medicaid beneficiaries under new modified adjusted gross income (MAGI) rules. These changes, designed to decrease the amount of paperwork received by beneficiaries and increase the use of automation, were first implemented in South Carolina in 2014. As with the traditional annual renewal process, individual beneficiaries that do not return the evidence necessary to maintain Medicaid eligibility exit the program after due notice.

Due to an above average number of individuals who received but did not return annual review forms mailed in April 2018, the number of individuals exiting the Medicaid program on June 1 was also above average.

This Medicaid Alert is to remind providers that under federal rules, individuals who lose Medicaid coverage for failing to return renewal forms on a timely basis may have their coverage restored – provided that they continue to meet other Medicaid eligibility rules – by submitting a renewal form within 90 days of their coverage loss. In this case, South Carolina Department of Health and Human Services (SCDHHS) will deem the individual's coverage to have been continuous, as if there had never been a break in coverage. Providers serving Medicaid beneficiaries that have recently lost coverage should encourage them to return annual review forms (Form #WKR002, attached) to SCDHHS so that services rendered may continue to be reimbursed by the agency. One-third of the individuals who lost coverage on June 1 have already regained it through this process.

If there are questions about a patient's eligibility or enrollment in a managed care plan, providers can check their status using the provider web tool, portal.scmedicaid.com. Beneficiaries who have questions regarding their Medicaid coverage should call the Healthy Connections Member Contact Center at (888) 549-0820.

Thank you for your continued support of the South Carolina Healthy Connections Medicaid program.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Annual Review Form

Household #:

Notification Date:

You have 30 days from the date listed above to complete and return this form. If you do not, you may lose Medicaid benefits.

Send to: SCDHHS-Central Mail
PO Box 100101
Columbia, SC 29202-3101

things to know

What do I do with this form?

- **Please complete this form and return it by the date listed above** so that we can determine if you and your family still qualify for Medicaid. If you do not return this form, your Medicaid benefits will end.

What if my household has changed?

- If a member has moved out of your home, indicate that they no longer live with you in Step 2. If someone has moved into your home, use the New Household member page to add them.

What do I need to complete this form?

- 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
- The rights and responsibilities you agreed to on the original application are still in effect, so no signature is required on this form.

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, please visit: **www.scdhhs.gov**

What happens next?

Send your complete review form to the address in Step 6. **If you don't have all the information we ask for, return your review form anyway; we'll follow up with you.** If you don't hear from us, visit **SCDHHS.gov** or call 1-888-549-0820.

Get help with this form

- **Visit us online at SCDHHS.gov**
- **Call our Help Center at 1-888-549-0820**.
- **In person:** Visit an SCDHHS county eligibility office in your area.

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, 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: 1-800-368-1019, 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).

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

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 हदी 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 ကျိာ်အဃိ, နမၤန့် ကျိာ်အတၢ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နူဉ်လီၤ. 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 ့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ်ဆိုပါ။

NEED HELP WITH YOUR REVIEW? Visit **SCDHHS.gov** or call us at **1-888-549-0820 (TTY: 1-888-842-3620)**

STEP 1 Tell us about yourself.

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

REVIEW your contact information here ▼	**CORRECT** any wrong or missing information here ▼
Name:	First name, Middle name, Last name and Suffix
	Home address
	Address Line 2
Household #:	City / State / ZIP code
Home address:	Mailing address (if different from home address)
	Address Line 2
	City / State / ZIP code
Mailing address:	Phone number / Other phone number
	County
	Do you want to get information about this review by e-mail? ☐ Yes ☐ No
	Email address:
	What is your preferred spoken or written language (if not English)?
Other:	

STEP 2 Tell us about your household.

The following list represents the additional person(s) in your household who may or may not be receiving Medicaid. Members that we have already typed in below are up for review and their coverage will end if you do not provide information about them on this form. Write in the names and information about other members. If you need to add more people, make a copy of this page to add them. If a member has moved out of your home, please indicate that change in the table below. **If someone has moved into your home, use the "New Household Member" page to see if they qualify.**

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

Authorized Representative

An Authorized Representative is a person, named by you, who has permission to get information about this review, sign it, and to act for you in matters relating to this review.

If your authorized representative's information has changed, if you would like a different authorized representative, or if you want to appoint a new one, please write the new information below. ▼

Name of Authorized Representative (First name, Middle name, Last name)		Phone
Street One	Street Two	
City	State	ZIP code

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 Step 3. ☐ **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
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ YES ☐ NO If YES, tribe name: _____	☐ YES ☐ NO If YES, tribe name: _____
3. 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
4. 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 designated 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).

1. First name, Middle initial, Last name, & Suffix

2. Relationship to Person 1?

SELF

3. Date of birth (mm/dd/yyyy)	4. Gender:	5. Social Security number (SSN)
		- -

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 name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you 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. 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 full-time student? ☐ Yes ☐ No

14. Were you in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

15. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

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

16. **Race (OPTIONAL—check all that apply)**

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

Now, tell us about any jobs and income on the next page.

STEP 3 Continue with yourself.

Current job & income information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 17.

☐ **Not Employed**
SKIP to question 29.

☐ **Self-Employed**
SKIP to question 28.

CURRENT JOB 1:

17. Employer name and address _____ 18. Employer phone number _____

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

$ _____ 20. Average hours worked each week _____ 21. Start date _____

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

22. Employer name and address _____ 23. Employer phone number _____

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

$ _____ 25. Average hours worked each week _____ 26. Start date _____

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

28. **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?
$ _____

29. **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 acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

30. **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 (question 28b).

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

31. **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)
$ _____

THANKS! This is all we need to know about you.

STEP 3: PERSON

Tell us about household members currently enrolled in your Medicaid plan. If you need to add more than the currently enrolled members, please use the New Household Member section. If you need to add more than one member, please make copies of New Household Member as needed.

1. First name, Middle initial, Last name, & Suffix

2. Relationship to Person 1?

3. Date of birth (mm/dd/yyyy)	4. Gender:	5. Social Security number (SSN)
		- -

6. **Does this person 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 this person file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse:

b. Will this person claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents:

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is this person related to the tax filer? _____

7. Is this person pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? _____ b. What is the 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

8. **Does this person 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. Leave the rest of this page blank.

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

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

11. 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)

12. Does 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

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

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

15. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

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

16. **Race (OPTIONAL—check all that apply)**

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

Now, tell us about any jobs and income on the next page.

STEP 3: PERSON

Current job & income information

☐ **Employed**
If currently employed, tell us about income.
Start with question 17.

☐ **Not Employed**
SKIP to question 29.

☐ **Self-Employed**
SKIP to question 28.

CURRENT JOB 1:

17. Employer name and address _____

18. Employer phone number _____

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

$ _____ 20. Average hours worked each week _____ 21. Start date _____

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

22. Employer name and address _____

23. Employer phone number _____

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

$ _____ 25. Average hours worked each week _____ 26. Start date _____

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

28. **If self-employed, answer the following questions:**
a. Type of work _____

b. How much net income (profits once business expenses are paid) will this person get from this self-employment this month?
$ _____

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often this person gets 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 acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often this person gets it.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

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

31. **YEARLY INCOME: Complete only if this person's income changes from month to month.**

Your total income this year
$ _____

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

THANKS! This is all we need to know about this person.

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 new person, make blank copies of this section to add them.

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

2. Relationship to Person 1?

3. Date of birth (mm/dd/yyyy)

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

We need this if this person wants health coverage and has a SSN.

a. If no SSN, has this person applied for one? ☐ Yes ☐ No
If no, indicate the reason at question 16.

6. Live at the same address as Person 1? ☐ Yes ☐ No

If no, list address: _____

7. **Does this person 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 this person file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse: _____

b. Will this person claim any dependents on a tax return? ☐ Yes ☐ No

If yes, list dependents: _____

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the tax filer: _____ How is this person related to the tax filer? _____

8. Is this person pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? _____ b. 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

9. **Does this person 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. Leave the rest of this page blank.

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

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

12. 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)

13. Does 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.

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

15. **If this person isn't a U.S. citizen or U.S. national, does this person have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in this person's document type and ID number below.

a. Immigration document type: _____ b. Document ID number: _____

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

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

16. If this person has 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 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: $ _____

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

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

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

21. Is this person currently living in a foster home? ☐ Yes ☐ No

22. Is this person currently living in a DJJ group home? ☐ Yes ☐ No

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

NEW HOUSEHOLD MEMBER

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 person is currently employed, tell us about the 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 person:** ☐ 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 this person get from this self-employment this month?)
$ _____

37. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often this person gets 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 acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

38. **DEDUCTIONS:** Check all that apply, and give the amount and how often this person gets it.
If this person 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? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions: $ _____ How often? _____
Type: _____

39. **YEARLY INCOME: Complete only if this person's income changes from month to month.**
If you don't expect changes to this person's monthly income, you may add another person or continue to the next step.

Total income this year
$ _____

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

STEP 5

Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted.

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 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.
6. I know that I must tell SCDHHS within 10 days if any information I listed on this review changes and is different than what I wrote on this review. 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 review 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.

(Rights and responsibilities continued on next page)

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 from 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/dd/yyyy) _____

STEP 6 Mail the completed review.

Mail your review 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**.

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