SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notification Date:

Annual Review Form

DUE DATE: _____ **Case #:** _____

If you have not returned this form or started your review online by the due date, we will begin the process to close your case and end your benefits.

Complete your review online

You also have the option to complete your review online. To get started, visit apply.scdhhs.gov or scan this QR code with your mobile device.

Why must I return this form?

- If this completed, signed form is returned by the due date, current benefits may continue.
- You should complete your review, even if you don't think you still qualify for Medicaid. You may still be eligible for federal Marketplace coverage.
- If we **do not** receive this form by the due date, we will send a notice listing the date when your Medicaid 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

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, signed 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 **www.SCDHHS.gov** or call 1-888-549-0820.

Get help with this form

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

Accessibility Options – Auxiliary Aids and Services This form and other documents and info are available for free in other languages. Please call the Healthy Connections Member Contact Center at 1-888-549-0820, 8 a.m. – 6 p.m. Monday-Friday. The call is free. You can also ask for this information in other formats, such as Braille.

Your current Medicaid household.

The person(s) listed below are up for review and their coverage will end if you do not provide information about them on this form. We need information for everyone listed, not just ones with a closure date associated with this review. **Check the "Moved Out of Household" box for each person who moved out of your household last year, otherwise leave the box blank.** If someone new has moved into your home, write in the information in Step 2.

Full Name	Date of Birth (mm/dd/yyyy)	Gender	Eligibility Will End On	Moved Out of Household?
				☐
				☐
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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
Household #:	Home address
	Address Line 2
Home address:	City / State / ZIP code
	Mailing address (if different from home address)
	Address Line 2
Mailing address:	City / State / ZIP code
	Phone number / Other phone number
	County
	Do you want to get information about this review by e-mail? ☐ Yes ☐ No
Other:	Email address:
	What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about changes to your household.

Write in the names and information about others who have moved into your household in the last year. **If someone has moved into your home, use the "New Household Member" page to see if they qualify for Medicaid.**

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

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

Authorized Representative

An authorized representative (AR) 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. ***Note:*** If you want to add a new AR or change your existing AR, we will send you a form to fill out and return (Form 1282). We will continue to process this review and your eligibility will not be affected by adding or changing your authorized representative.

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 still need health coverage (Medicaid)?**

☐ 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. a. Were you in foster care and enrolled in Medicaid on your 18th birthday? ☐ Yes ☐ No

b. If yes, what state did you reside in when you aged out of foster care? _____

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.

☐ 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 still need health coverage (Medicaid)?**
☐ 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. a. Was this person in foster care and enrolled in Medicaid on their 18th birthday? ☐ Yes ☐ No

b. If yes, what state did they reside in when they aged out of foster care? _____

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: _____

STEP 3: PERSON

☐ **Employed**
If currently employed, tell us about the 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 this person has 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 you 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.

☐ 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.**
If this person doesn't expect changes to monthly income, you may add another person on the following pages, if needed.

Total income this year

$ _____

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 (Medicaid)?**

☐ 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. Date of Entry: _____

e. 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. a. Was this person in foster care and enrolled in Medicaid on their 18th birthday? ☐ Yes ☐ No

b. If yes, what state did they reside in when they aged out of foster care? _____

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

23. **If Hispanic/Latino, ethnicity (OPTIONAL)**

☐ Mexican ☐ Mexican-American ☐ Chicano/a

☐ Puerto Rican ☐ Cuban ☐ Other: _____

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: _____

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

NEW HOUSEHOLD MEMBER

☐ **Employed** If currently employed, tell us about the income. Start with question 24.

☐ **Not Employed** SKIP to question 36.

☐ **Self-Employed** SKIP to question 35.

CURRENT JOB 1:

24. Employer name and address _____ 25. Employer phone number _____

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

$ _____ 27. Average hours worked each week _____ 28. Start date _____

CURRENT JOB 2: (If this person has more jobs and need more space, attach another sheet of paper)

29. Employer name and address _____ 30. Employer phone number _____

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

$ _____ 32. Average hours worked each week _____ 33. Start date _____

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

35. 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? $ _____

36. 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? _____

37. 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.

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions: $ _____ How often? _____

Type: _____

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

If this person doesn't expect changes to monthly income, you may add another person on the following pages, if needed.

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, Medicare, or Medicaid from another state (other than SC)? ☐ 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 for Medicaid-related complaints by either calling or writing the SCDHHS Civil Rights Division at (888) 808-4238 or 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, SCDHHS 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 request for such a hearing to SCDHHS in writing, by phone, in person, or I may appeal online at www.scdhhs.gov/appeals. 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 Insuranc 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

(Rights and responsibilities continued on next page)

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

Medicaid

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.

By signing, I state that I have read and agree to the rights and responsibilities stated on this review. I am signing this form under penalty of perjury. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I am not truthful, there may be a penalty under federal law.

Signature _____ Date (mm/dd/yyyy) _____

(Don't forget to sign the form)

STEP 6 Submit the completed, signed review form.

You can submit this form in one of the ways below:

- Upload – Use our document upload tool at apply.scdhhs.gov to upload this form
- Fax – (888) 820-1204
- Email – 8888201204@fax.scdhhs.gov
- Mail – SCDHHS Central Mail, PO Box 100101, Columbia, SC 29202
- In Person – Visit www.scdhhs.gov for a list of local eligibility offices

You also have the option to complete your review online. Visit apply.scdhhs.gov and select "Submit Annual Review" to get started.

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 Healthy 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.