SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notification Date:

Annual Review Form - Institutional and HCBW

DUE DATE: **Case #:**

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

Why must I return this form?

- **Please return this form by the due date.**
- If this completed form is returned by the due date, current benefits may continue.
- Once we complete the review, we will send a notice with the updated eligibility decision.
- 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. 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 & income information for everyone in your family (paystubs, W-2 forms, tax statements)
- Policy numbers for any current health insurance
- Information about various assets (property, vehicles, etc.)

Proof of income

- If you would like to save time, you can attach proof of wages or other income with this review form.
- **Wages from employer:** Include income, including tips, for the 4 weeks prior to the date you received this review. Examples of proof of wages include check stubs, award letters, printouts, or a statement on letterhead from the company, agency, or payor.
- **If self-employed,** you may attach your most recent tax return. Provide all tax returns and schedules, both personal and business (Schedule C), if applicable.
- If income from a retirement or investment account, provide **entire financial account statements** (not account summaries), for the 4 weeks prior to the date you received this review.

What are assets?

- Assets are things that you own, such as cars, boats, non-homestead property, bank accounts, cash and CDs.
- Equity value is how much something is worth minus any money owed on it. (For example, if you have a vehicle that is valued at $5,000 and you owe $2,000 the equity value is $3,000.)
- Do not count values of the home you live in or up to two vehicles.

Why do we ask for this information?

We ask about income and asset 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 at the end of the form. **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.

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	Case Will Close 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		
ID Number:	Home address		
	Address Line 2		
Home address:	City	State	ZIP code
	Mailing address (if different from home address)		
	Address Line 2		
	City	State	ZIP code
Mailing address:	Phone number	Other phone number	
	County		
Other:	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)?		

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

Authorized Representative (AR)

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. ***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: PERSON 1

Tell us about the primary beneficiary (Person 1). This is the person in the facility or receiving waiver services.

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. Medicare Number (if applicable)

7. **Does this person still need health coverage (Medicaid)?** *(Even if this person has 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.

8. 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. Enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. Has this person been diagnosed with and is receiving treatment for any of the following? ☐ Yes ☐ No
   • Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia
   • Precancerous Cervical Lesion (CIN 2/3)

10. Does this person pay for child care, or for care for a disabled adult, so this person can go to work or school? If Yes, send proof of payment. ☐ Yes ☐ No

11. Has there been a change in this person's immigration status? ☐ Yes ☐ No
    (If No, skip question 12)

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

Household Income and Resource Information

13. Has anyone in the household ever worked somewhere that has a retirement benefit, military retirement or VA benefit for which he or she may be eligible to receive money? ☐ Yes ☐ No
    If yes, who was working, where, and for how long?: _____
14. Has anyone in the home stopped working within the past year? ☐ Yes ☐ No
    If yes, tell us who was working, where, and when the job ended: _____
15. Has anyone received an inheritance in the last five years? ☐ Yes ☐ No
    If yes, from whom? _____
    Date of Death _____ State/County where estate was probated _____

STEP 3: Person 1

16. Tell us about the income of each family member in the home.

Job 1

Name of person working:

Employer's Name:

Employer's Address:

Employer's Phone Number:

Amount earned per pay period before taxes: $

How often paid? ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month

Average hours worked each week: Start date:

In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours

Job 2

Name of person working:

Employer's Name:

Employer's Address:

Employer's Phone Number:

Amount earned per pay period before taxes: $

How often paid? ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month

Average hours worked each week: Start date:

In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours

17. Is anyone self-employed? ☐ Yes ☐ No Type of work _____

Name of self-employed person: _____

Name of the business: _____

How much net income will the person get from the self-employment this month? $_____

18. Check all other income sources that apply for anyone in the household and complete the table below.

☐ Social Security benefits (RSDI)
☐ Federal retirement (Civil Service, FERS)
☐ Disability benefits
☐ Veterans Administration (VA) benefits
☐ Pension/retirement benefits
☐ Supplemental Security Income (SSI)
☐ Child support
☐ Rental income
☐ Alimony
☐ Unemployment
☐ Money from friends or relatives
☐ Worker's compensation
☐ Military allotments
☐ Land contract, mortgage or other notes payable to a household member
(Please provide a copy of the contract, mortgage, note or other agreement)

☐ Other: _____

Person receiving money	Income Source	How often received	Amount received	Comments
			$	
			$	
			$	
			$	
			$	
			$	
			$	
			$	
			$	
			$	

STEP 3: Person 1

19. Does this person or his/her spouse own any property, including property in other states?
If YES, check the boxes that apply and tell us about the property. ☐ Yes ☐ No

☐ Home (house, buildings and land where you live) ☐ Land (not connected to current home)
☐ Other House or Building (not your home) ☐ Vacation Home or Time Share Property

a. What is the address/location of the property? (List home property first)

b. What is the address/location of other property?

Owner's Name: _____ Owner's Name: _____

Is 19-a this person's Home Property or Primary Residence where he/she currently lives or where he/she wants to return to live if living somewhere else? ☐ Yes ☐ No

20. Please check the box beside any of the items that this person or his/her spouse or dependent(s) owns or is buying. Tell us about it in the table below.

☐ Bank Checking Account ☐ Bank Savings Account ☐ Car, Truck, Van
☐ Certificate of Deposit ☐ Motorcycle, Boat, Camper ☐ Annuity (provide a copy)
☐ Trust Fund or Trust Account ☐ Pre-Need Burial Contract ☐ Cash on Hand
☐ Money Set Aside for Burial ☐ Cemetery Burial Space ☐ Life Insurance
☐ 401k, IRA, or Retirement Account ☐ Stocks, Bonds, Mutual Funds
☐ Farm Machinery or Business Equipment ☐ DirectExpress Debit Card for SSA, SSI or other benefits
☐ Other: _____

Owned by	Tell Us About the Asset Include the name of bank or funeral home and any account numbers or other information used to identify the asset.	Current Value or Balance
		$
		$
		$
		$
		$

NOTE: When you return this form, you must send proof of these assets or resources, including any supporting documents.

21. Has this person closed any bank accounts in the past year? If yes, what bank? ☐ Yes ☐ No

Bank _____ Date Closed _____ Closing Amount $_____
Bank _____ Date Closed _____ Closing Amount $_____

22. Has this person or spouse sold or given away any cash, property, or other resource to any person within the past year? ☐ Yes ☐ No

Item: _____ Given To: _____ Date: _____ Amount Received $ _____
Item: _____ Given To: _____ Date: _____ Amount Received $ _____

STEP 3: Person

Tell us about this household member. If you need to add more members to the household, please use the New Household Member section. If you need to add more than one member, please make copies of the New Household Member section 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. Medicare Number (if applicable)

_____

7. **Does this person still need health coverage (Medicaid)?** *(Even if this person has insurance, there might be a program with better coverage or lower costs.)*

☐ Yes. If yes, answer all the questions below.
☐ No. If no, return to the income questions in Step 3: Person 1 to enter income information for this person, if you have not done so already. Leave the rest of this page blank.

8. 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. Enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. Has this person been diagnosed with and receiving treatment for any of the following? ☐ Yes ☐ No
   • Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia
   • Precancerous Cervical Lesion (CIN 2/3)

10. Does this person pay for child care, or for care for a disabled adult, so this person can go to work or school? If Yes, send proof of payment. ☐ Yes ☐ No

11. Has there been a change in this person's immigration status? ☐ Yes ☐ No
    (If No, skip question 12)

12. 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

NEW HOUSEHOLD MEMBER

If you have a new person in your household, you may complete this section to tell us about them. This information can also be used 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 initial, Last name, & Suffix	2. Relationship to Person 1?

3. Date of birth (mm/dd/yyyy)	4. Gender	5. Social Security number (SSN) *We need this if this person wants health coverage.*
		a. If no SSN, has this person applied for one? ☐ Yes ☐ No If no, indicate the reason at question 14.
6. Medicare Number (if applicable)		

7. **Does this person want to apply for health coverage (Medicaid)?** *(Even if this person has insurance, there might be a program with better coverage or lower costs.)*

☐ Yes. If yes, answer all the questions below.
☐ No. If no, return to the income questions in Step 3: Person 1 to enter income information for this person, if you have not done so already. Leave the rest of this page blank.

8. 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. Enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. Has this person been diagnosed with and receiving treatment for any of the following? ☐ Yes ☐ No
   • Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia
   • Precancerous Cervical Lesion (CIN 2/3)

10. Does this person pay for child care, or for care for a disabled adult, so this person can go to work or school? If Yes, send proof of payment. ☐ Yes ☐ No

11. Has there been a change in this person's immigration status? ☐ Yes ☐ No
    (If No, skip question 12)

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

13. If no, 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

14. 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 NOT receiving Medicaid
    ☐ Newborn, mother currently receiving Medicaid

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

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

NEW HOUSEHOLD MEMBER

17. Was this person in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No
18. Does this person plan to file a federal income tax return NEXT YEAR?
    ☐ YES. If yes, please answer questions a–c.
    (You can still apply for health insurance even if you don't file a federal income tax return.)
    ☐ 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? _____
19. Does this person have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
20. Does this person need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
21. 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 this person for Family Planning.
22. 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 three 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: $_____
23. Is this person currently living in a foster home? ☐ Yes ☐ No
24. Is this person currently living in a DJJ group home? ☐ Yes ☐ No
25. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

    ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban
    ☐ Other:
26. **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 4 Your family's health coverage

Did anyone add or drop private health insurance, Medicaid from another state (other than South Carolina), or Medicare? ☐ Yes ☐ No

If you didn't add or drop, please leave blank. If added, please send a copy of the insurance card (front and back). If you have dropped insurance, please send a copy of the termination letter.

Policy holder	List everyone covered by this insurance	Name of insurance company	Policy number / Medicaid number	Change
				☐ Added ☐ Dropped
				☐ Added ☐ Dropped
				☐ Added ☐ Dropped

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 (TTY: 1-888-842-3620) 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, 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

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.

By signing, I state that I have read and agree to the rights and responsibilities stated on this review. I am signing this application 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) _____

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 by the Due Date listed on Page 1.

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.