

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 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.

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.