SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Application for Nursing Home, Residential or In-Home Care

This application is used to apply for Nursing Home, Waiver Services, or Optional State Supplementation (OSS) at the South Carolina Department of Health and Human Services (SCDHHS). Please answer all questions as completely as possible as they apply to you or the persons for whom you are applying. If you need help filling out this application, you can call 1-888-549-0820 (TTY 1-888-842-3620).

I am applying for: ☐ Nursing Home ☐ Waiver Services ☐ OSS

☐ Presumptive Disability **This box for pilot use only**
Who? _____

Federal law requires that anyone who applies for Medicaid for themselves must tell us about their citizenship or immigration status and provide or apply for a Social Security Number (SSN). We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. SSNs provided will be used to help the State agency determine eligibility. Each non-citizen applying for full Medicaid benefits must provide United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94. Anyone applying as a non-citizen for emergency services only is not required to provide USCIS documents or a SSN.

Some family members of applicants may choose not to apply for Medicaid. In that case, they do not have to provide a SSN or citizenship or immigration status but will be required to provide information about their income and assets. Benefits to applicants will not be delayed or denied just because some family members do not wish to apply for themselves. Even though a person not applying for Medicaid is not required to provide a SSN, it is helpful for us to have this number as we gather the information we need to make a decision. We use SSN to help us check identity, verify eligibility and prevent fraud. We exchange information with other agencies according to Federal rules and to manage our programs.

How do I apply for benefits?

- You must fill out this application using Black or Blue ink or by Typing your answers. You are also able to apply online by going to www.SCDHHS.gov.
- Attach extra sheets if you need more space to answer any of the questions.
- You may mail your application to: SCDHHS PO Box 100101 Columbia, SC 29202-3031.
- To be valid, the application must have your name, contact information and be signed.
- If we do not have everything we need, you will get a list of what you need to send us.
- When we have everything we need, a decision will be made about your Medicaid eligibility. You should receive a letter within 45 days from the date we receive your application to tell you if you are eligible. If you need a disability determination, it may take up to 90 days.
- Immediately report any change in income or other information on your application to your local Medicaid office or by calling the call center at 1-888-549-0820.
- We may share this information with other Federal and state agencies as we gather what we need to make a decision.

Date Application Received by DHHS: _____

1. Tell us who is the person that needs help (Applicant) and how we can get in touch.

Name (First, Middle Initial, Last)			**County** (Where you live)	**Do you want to get information about this application by email?** ☐ **Yes** ☐ **No** **E-Mail Address:**
Home or Street Address (include apartment or lot number)	**City**	**State**	**Zip Code**	
Mailing Address (If different from where you live)	**City**	**State**	**Zip Code**	**What is your preferred language?** **Spoken** ☐ English ☐ Spanish ☐ Other: **Written** ☐ English ☐ Spanish ☐ Other:
Phone Numbers **Home:**	**Work:**	**Cell:**		

2. Tell us about the person(s) who needs nursing home, long term care, or residential care. Please include any dependents the person may have, such as a spouse or children.

This information is Optional for:
- Anyone not applying for Medicaid coverage;
- A non-citizen applying for Emergency Services Only

	Name	Relationship to the Applicant * (Use Relationship Codes shown below)	Marital Status Single, Married, Divorced, Widowed, Separated	Date of Birth	Sex	Is this person applying for Medicaid?	**See below Is this person applying for Family Planning?	Social Security Number	Race *** (Race codes shown below)	Is this person a US citizen?
1.	Applicant				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No
2.	Spouse				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No
3.					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No
4.					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No
5.					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No

*** Relationship Codes:** **SP** Spouse **BF/GF** Boyfriend/Girlfriend **NR** Not Related **OTH** Other **CH** Child (Natural or Adopted) **SC** Step-Child **GC** Grandchild **NE** Niece/Nephew

***** Race Codes:** **01** White/Caucasian **02** Black/African American **03** Multi Race **04** Federally Recognized Native American *(Requires Verification)* **05** Other Native American **06** Alaska Native **07** Asian **08** Other/Unknown **09** Native Hawaiian/Pacific Islander **10** Hispanic

****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.

3. Please tell us if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant. If yes, please give us a copy of the legal or court papers and the name and phone number of the person.

☐ Conservatorship Name and Phone Number: _____

☐ Guardianship Name and Phone Number: _____

☐ Power of Attorney Name and Phone Number: _____

4. **Do you or someone you are applying for want nursing home services, either in a nursing home or at home?** ☐ **Yes** ☐ **No**
   If yes, who: _____ ☐ Nursing Home ☐ Services at Home

5. **Do you or someone you are applying for want to go into a Residential Care Facility/Boarding Home?** ☐ **Yes** ☐ **No**
   If yes, who: _____

6. **Are you or someone you are applying for currently in a Hospital, Nursing Home, or Residential Care Facility?** ☐ **Yes** ☐ **No, at Home**
   If yes, who: _____ Date Entered: _____ Where: _____

7. **Are you blind, disabled, or applying for someone who is blind or disabled?** ☐ **Yes** ☐ **No**

Name of Blind or Disabled Person	Is this Person Receiving or Applying for Social Security or SSI
	☐ Receiving Social Security or SSI ☐ Applying for Social Security or SSI
	☐ Receiving Social Security or SSI ☐ Applying for Social Security or SSI

8. **Have you or someone you are applying for received medical services in the past three months?** ☐ **Yes** ☐ **No**

Person(s) Receiving Medical Services	Months Services Received
You will have to give us information about income and assets for each month to see if the person may be Medicaid eligible	

9. **Did you or someone you are applying for retire from the military, have a service related disability, OR are the spouse or dependent of someone who has retired from the military or has a service related disability?** ☐ **Yes** ☐ **No**
   If Yes, tell us who? _____

10. **Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money?** ☐ **Yes** ☐ **No**
    If yes, who was working, where and for how long? _____

11. **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.
    _____

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

☐ **NO ONE IN THE HOME HAS ANY INCOME**
If checked, explain how you pay your bills

Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks.

Income from Employment	Income from Employment
Name of person working _____	Name of person working _____
Employer's Name _____	Employer's Name _____
Employer's Address _____	Employer's Address _____
_____	_____
_____	_____
Employer's Phone Number (including area code) _____	Employer's Phone Number (including area code) _____
Gross amount earned per pay period before taxes? $_____	Gross amount earned per pay period before taxes? $_____
How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
When is it paid?	When is it paid?

Is anyone self-employed? ..... ☐ **Yes** ☐ **No**

If yes, please send copies of all the Personal and Business Federal income tax forms most recently filed with the IRS. Include all forms and schedules.

Please tell us who is self employed and the name of the business:

Do you or anyone in your home receive, or have applied for, any other income? ..... ☐ **Yes** ☐ **No**

If Yes, check all boxes that apply and complete the table below

☐ Social Security benefits (RSDI) ☐ Supplemental Security Income (SSI) ☐ Child Support
☐ Disability benefits ☐ Pension/retirement benefits ☐ Unemployment benefits ☐ Rental Income
☐ Veterans Administration (VA) benefits ☐ Military allotments ☐ Money from friends or relatives ☐ Alimony
☐ Worker's Compensation ☐ Federal Retirement (Civil Service, FERS)
☐ 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/expecting money	Income source/type	How often received	Amount received	Comments

13. Look at the list below. Check the box for anything on the list that you, your spouse, or other person in your home may own. For anything that you check, please tell us about it on the lines below.

When we start working on your application, you may be asked to send in proof of the assets you tell us about.

☐ Bank Checking Account	☐ Bank Savings Account	☐ Certificate of Deposit	☐ Trust Fund or Trust Account
☐ Safe Deposit Box (Include a list of the contents)	☐ Car, Truck, Van	☐ Annuity (If Yes, provide a copy)	☐ Cash on Hand
☐ Stocks, Bonds, or Mutual Funds	☐ Motorcycle, Boat, Camper	☐ Farm Machinery or Business Equipment	☐ Life Insurance
☐ 401K, IRA or other Retirement Account	☐ Pre Need Burial Contract	☐ Cemetery Burial Space	☐ Money Set Aside for Burial
☐ DirectExpress Debit Card for SSA, SSI or other benefits	☐ Other (Please be specific):		

Owned By	Tell us about the asset Include the location, such as the name of bank or funeral home, and any account numbers or other information used to identify the asset	Current Value or Balance

14. Do you or your spouse own any property? *If you answer **YES** to any of the following questions, please tell us about the property on the next page.*

Home (house, buildings and land where you live) ☐ Yes ☐ No
Land (not connected to the home) ☐ Yes ☐ No
Other House or Building (not your home) ☐ Yes ☐ No
Vacation Home or Time Share Property ☐ Yes ☐ No

What is the address/location of the property? *List Home Property First*

_____

_____

_____

Owner's Name: _____

Is this your Home Property or Primary Residence where you currently live or where you want to return to live if you are living somewhere else? ☐ Yes ☐ No

What is the address/location of the property?

_____

_____

_____

Owner's Name: _____

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

Policy Holder	List everyone covered by the insurance	Name of Insurance Company	Policy Number or Medicare Number

Please include a copy of the front and back of all health insurance cards

If applying for nursing home services, either in a nursing home or at home, Please answer questions 16 through 24

16. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to a spouse remaining at home? ☐ Yes ☐ No

17. If there are dependent children or dependent adult, does the applicant want to give (allocate) income to the dependent children or dependent adult? ☐ Yes ☐ No

18. Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money? ☐ Yes ☐ No

If yes, who was working, where and for how long? _____

19. Does anyone have a bank account, or any other asset, for the applicant or spouse? ☐ Yes ☐ No

If yes, at what bank or location, and in whose name(s)? _____

_____

20. Has the applicant or spouse closed any bank accounts in the past five (5) years? ☐ Yes ☐ No

If yes, at what bank and in whose name(s)?

A. _____

_____

_____

Date Closed: _____

Closing Balance: _____

B. _____

_____

_____

Date Closed: _____

Closing Balance: _____

21. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time in the past five (5) years? ☐ Yes ☐ No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received

22. Where has the applicant lived in the past five (5) years?

City	County	State	From	To

23. If ever married, give the following information about the applicant's spouse(s). *(List the most recent first.)*

Name:

☐ Living
- ☐ In a medical facility
- ☐ Married living together
- ☐ Married living apart (Not Separated)
- ☐ Separated – When or How long? _____
- ☐ Divorced Date and State/County where filed: _____

Current Address: Phone Number:

☐ Deceased Date of Death: _____ State and County where estate was probated: _____

Name:

☐ Divorced Date of Divorce: _____ State and County where divorce was filed: _____
☐ Deceased Date of Death: _____ State and County where estate was probated: _____

Name:

☐ Divorced Date of Divorce: _____ State and County where divorce was filed: _____
☐ Deceased Date of Death: _____ State and County where estate was probated: _____

24. Has the applicant received an inheritance in the last five years? ☐ Yes ☐ No

If YES, from whom? _____

Date of Death: _____ State/County where estate was probated _____

Additional inheritance?

If YES, from whom? _____

Date of Death: _____ State/County where estate was probated _____

PLEASE READ THE FOLLOWING RIGHTS AND RESPONSIBILITIES AND SIGN THE APPLICATION ON PAGE 9

Rights and Responsibilities

Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the 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.

Rights and Responsibilities

6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.
8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid program, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing. I must submit a 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 Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

- 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'm not truthful, there may be a penalty under federal law.
- By signing I state that I have read and agree to the rights and responsibilities stated on this page.

Applicant's Signature: _____ Date: _____

If the applicant signs with an "X", the signature must have two witnesses

If you are an authorized representative you may sign the application above as long as you have provided the information on FM 1282 (attached).

Witness 1: _____ Date: _____

Witness 2: _____ Date: _____

Do you want to name someone as your Authorized Representative for your case? ☐ Yes ☐ No

If you name an Authorized Representative, there is a form for you to sign to give us permission to talk to this person about your case. We will also be able to send all letters and notices to this person. Please check if this person has ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship for you and include a copy if possible.

Please tell us about the person you would like to be your Authorized Representative:

Name: _____ Relationship: _____

Please sign if you have filled out this application for someone:

Signature: _____ Date: _____

I helped the applicant complete this application or I am applying for someone who is unable to act on his/her own behalf. I understand that anyone helping an individual to receive benefits dishonestly is subject to criminal penalties. I certify that the answers on this form:

☐ Were provided by the applicant/beneficiary ☐ Are what I personally know about him or her.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

Name of Medicaid applicant/member	Social Security Number

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your case?

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an "authorized representative." The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

Name of Authorized Representative (First name, Middle name, Last name)	☐ New ☐ Change ☐ Addition ☐ Remove this person or organization as my authorized representative

Authorized Representative's address (Leave blank if you don't have one.)	Apartment or suite number

City	State	ZIP code

Authorized Representative's phone number	Other phone number

Authorized Representative's email address

Organization name (if applicable)	Unit* (if applicable)	ID number (if applicable)

*It is best to identify a specific unit for large organizations.

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application?

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization		Phone	
Address	**City**	**State**	**ZIP**
Unit (if applicable)	**ID Number (if applicable)**		

Medicaid applicant/member's signature	Date (mm/dd/yyyy)

If signing with an "X," please have two people sign below as witnesses.

Witness: _____ Witness: _____

☐ Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member's inability to sign. Provide reason:

_____

Mail your signed form to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 **Fax:** (888) 820-1204

NEED HELP WITH YOUR APPLICATION? Visit **SCDHHS.gov** or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

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, braille, 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, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe 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, by mail, or via 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: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html