SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Additional Information for Nursing Home and In-Home Care

☐ **Nursing Home** ☐ **In-Home Care**

This form is used to gather other information needed to make a decision about eligibility for Nursing Home, Institutional or In-Home Care. Please answer the following questions as completely as possible as they apply to **the person who is applying and their spouse**. If you are applying on behalf of someone else, enter your name as the Authorized Representative. The rights and responsibilities you agreed to on the original application are still in effect. If you have questions, please contact Healthy Connections at (888) 549-0820 (TTY 1-888-842-3620). We may ask for additional information or documentation to establish your eligibility.

Name of person needing assistance (First, Middle, Last)

Social Security Number	Medicaid ID	Date of Birth (mm/dd/yyyy)

Authorized Representative (if applicable):	Relationship to Applicant

I. Statement of Transfers

1. In the past five years have you: ☐ Yes ☐ No

☐ Closed a Bank Account ☐ Closed an Investment Account ☐ Closed a Retirement Account
☐ Transferred Life-Estate Interest In Your Home or Any Other Property

If YES, fill in the following values, if known:

Accounts

Account	Date Closed	Closing Balance	Account	Date Closed	Closing Balance
		$			$
Account	Date Closed	Closing Balance	Account	Date Closed	Closing Balance
		$			$

Life Estate Interest

Property	Transfer Date	Appraised Value	Property	Transfer Date	Appraised Value
		$			$

2. In the past five years have you sold or given away your home? ☐ Yes ☐ No

If YES, fill in the following, if known:

Appraised Value	Sale Price
$	$

3. In the past five years have you sold or given away other real estate? ☐ Yes ☐ No

If YES, fill in the following values, if known:

Property	Appraised Value	Sale Price	Property	Appraised Value	Sale Price
	$	$		$	$
Property	Appraised Value	Sale Price			
	$	$	TOTAL	$	$

4. In the past five years have you sold or given away any motor vehicles, boats, or other recreational vehicle? ☐ Yes ☐ No

If YES, fill in the following values, if known:

Vehicle	Appraised Value	Sale Price	Vehicle	Appraised Value	Sale Price
	$	$		$	$
Vehicle	Appraised Value	Sale Price			
	$	$	TOTAL	$	$

5. In the past five years have you given away cash? ☐ Yes ☐ No

If YES:

Person to whom it was given	Date given	Amount
		$
		$

DHHS USE ONLY

CLTC Worker (If Applicable) (Print)

CLTC Worker Signature | **Date**

DHHS USE ONLY

II. Additional Information

6. Please check if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant. If yes, please enclose a copy of the legal papers.

☐ Conservatorship Name: _____ Phone _____

☐ Guardianship Name: _____ Phone _____

☐ Power of Attorney Name: _____ Phone _____

7. Where is the applicant right now? ☐ Home ☐ Hospital ☐ Nursing Home ☐ Other

If not at home, tell us where the applicant is:

Name of facility: _____

Date entered facility: _____

Did the applicant live at home at any time during the month he/she entered the nursing facility? ☐ Yes ☐ No

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

Street Address	City	County	State	From (date)	To (date)

9. 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

10. Does the applicant want to give (allocate) income to dependent adults living in the home or to dependent children? ☐ Yes ☐ No

11. Does anyone in the applicant's home (including the applicant or applicant's spouse, children or dependent adults) receive or has anyone applied for any other income? ☐ Yes ☐ No

Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks. In addition to the income you listed on your application, do you have any of the following? If **YES**, check all boxes that apply and complete the table below.

☐ Supplemental Security Income (SSI) ☐ Child support ☐ Disability benefits
☐ Veterans Administration (VA) benefits ☐ Military Allotments ☐ Other
☐ Federal Retirement (Civil Service, FERS) ☐ Money from friends or relatives
☐ Land contract, mortgage or other notes payable to a household member. (Please provide a copy of the contract, mortgage, note or other agreement.)

Person receiving/expecting money	Income source/type	How often received	Amount received
			$
			$
			$
			$

12. Has the applicant or spouse 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? _____

For how long? _____

13. 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 _____

14. Do you or your spouse own any property? (Include 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)

_____

_____

_____

Owner's Name: _____

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

_____

_____

_____

Owner's Name: _____

Is 14-a 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

15. Please check the box beside any of the items that the applicant, applicant's spouse or applicant's dependent(s) owns or are 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. You will be asked to send information for the month of application and at least three months prior to the application month.

16. If ever married, give the following information about the applicant's spouse(s).

☐ Never been married

Name of most recent spouse: _____

☐ Living
- ☐ In a medical facility
- ☐ Married, living together
- ☐ Married, living apart
- ☐ Separated: When or How Long? _____
- ☐ Divorced

Current Street Address	City	State	ZIP	Phone

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

Name of most recent spouse: _____

☐ Living
- ☐ In a medical facility
- ☐ Married, living together
- ☐ Married, living apart
- ☐ Separated: When or How Long? _____
- ☐ Divorced

Current Street Address	City	State	ZIP	Phone

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

ESTATE RECOVERY

(BE SURE TO GET A COPY OF THE ESTATE RECOVERY BROCHURE)

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 may 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.

Applicant or Authorized Representative's Signature	Date

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

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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