South Dakota Indigent Medication Program

New Application

Applications will be processed within 5 business days after completed application is received. **The entire application must be completed.** Please complete electronically or print clearly.

Assistant Information:

Name (person assisting the client with the completion of this form): _____

Agency Name: _____

Email Address: _____

Application Information:

Applicant Name: _____

First *MI* *Last*

Date of Birth: _____ Social Security Number (last 4 digits) XXX-XX-_____

Address: _____

Address *City* *State* *Zip Code*

Telephone Number: _____

Incarceration:

Are you currently incarcerated? Yes ___ No ___

If yes, where? _____ Release date? _____

Financial Information:

Total Number of Persons Living in Household (dependent on household income): _____

Annual Gross Income: All sources of earned and unearned income for the household members included above. Do not include any income earned from a child under the age of 18 or any dependent attending school.

1) Earned Income *(i.e. wages)* $_____
2) Unearned Income *(i.e. child support, TANF, SSDI)* $_____

Minus Annual Deductions/Expenses:

3) $_____ Earned Income Deduction *(Deduct 20% of Earned Income. Do not deduct 20% from unearned income.)*
4) $_____ Childcare Expenses *(up to $6,000/year)*
5) $_____ Child Support Payments
6) $_____ Annual out of pocket prescription medication costs and lab work

7) $_____ Annual health insurance premiums

8) $_____ Assistive devices purchased within the last 12 months

*(describe)*_____

Annual Net Income:

9) $_____ *(deduct lines 3 through 8 from line 1 and 2)*

Employment:

Are you currently employed? Yes ___ No ___

If no, are you actively seeking employment? Yes ___ No ___

If no, why?

_____

Insurance:

SSI/SSDI Application Status:

____ Applied/Pending

____ Denied

____ Appealed

____ Have not applied yet

____ Approved. Effective Date: _____

Do you currently have any insurance plan that pays for prescription drugs including Medicaid?

Yes ___ No ___

Do you have Medicare Benefits?

____ Part A (Hospital Insurance)

____ Part B (Medical Insurance)

____ Part D (Prescription Drug Coverage)

Have you applied for Medicare Part D insurance for your prescriptions? Yes ___ No ___

If yes, what plan are you on?

_____ If no, why not?

_____

Have you applied for any Patient Assistance Programs? Yes ___ No ___

Patient Assistance Programs:

If yes, which ones? _____

If no, why not? _____

Behavioral Health Provider:

Mental Health and/or Substance Use Disorder Provider: _____

Address: _____ Phone Number: _____

Participating Pharmacy: Yes ___ No ___

Pharmacy: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax (if known):_____

Participating Laboratory Services: Yes ___ No ___

Lab Center: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax (if known): _____

Medication	Dosage	Quantity Per Month	Can generic be used? (Y/N)	Why is this medication prescribed (Diagnosis)?	Co-Pay Amount

Lab Test	Frequency	Why is this lab test ordered? (Please list current medication that relate to labs being requested.)

____ I have reviewed a copy of the Department of Social Services' Notice of Privacy Practices and understand that I may ask questions about how my PHI will be used.

I declare and affirm under the penalties of perjury that this information has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

I agree to take all medications as prescribed by my healthcare provider.

I agree to inform the South Dakota Department of Social Services, Division of Behavioral Health if Medicaid, private health insurance, or patient assistance programs are obtained anytime within the approved application year.

I hereby authorize the Department of Social Services, Division of Behavioral Health to release and/or exchange information both orally and in writing, with respect to diagnosis and course of treatment of my mental illness and/or substance use disorder with any Mental Health Provider/Substance Use Disorder Provider, pharmacy, medical provider, provider of laboratory services, and/or pharmaceutical programs.

I acknowledge that the Department of Social Services, Division of Behavioral Health will pay for my psychotropic medication, medication assistance for the treatment of substance use disorders, to include cessation and/or maintenance treatment, and /or related laboratory work on a time-limited basis, as determined by the Department of Social Services, Division of Behavioral Health.

I understand the above criteria and the terms/conditions of my participation in the program offered through the Department of Social Services, Division of Behavioral Health.

I agree to the following as terms/conditions of this medication/laboratory funding agreement:

- I will take all psychotropic medication and medication for the assistance of treatment of substance use disorders, to include cessation and/or maintenance treatment medications as prescribed.
- I will be responsible to cover the cost of replacing lost or damaged medications.
- I will not sell, give away or otherwise distribute medications intended for personal use.
- I will keep all scheduled psychiatric/substance use provider appointments and comply with treatment.
- I will develop a plan for long term needs as state funding is limited.
- I understand that funding may end with no greater than a 30-day notice.
- I will continue to exhaust all other funding resources.
- I authorize the exchange/release of relevant and necessary medical/psychiatric/substance abuse information to the Department of Social Services, Division of Behavioral Health.
- I agree to inform the Department of Social Services, Division of Behavioral Health if Medicaid, private health insurance, patient assistance programs, and/or my financial status would otherwise change.
- I understand that failure to comply with the above-based requirements will result in my termination from the program and/or repayment.
- I understand that if this application is not complete or correct, this application will be destroyed.
- I understand that this application will be effective one year from the date originally signed.
- I understand that I may revoke my consent at any time and that revocation is effective upon receipt, except to the extent previously relied upon.

_____ _____

Signature – Client/Patient Date

_____ _____

Signature – Legal Representative of Client/Patient Date

(if applicable)

_____

Relationship to Client/Patient

Return To:

Division of Behavioral Health Phone: (605) 367-5236

3900 W Technology Circle, Suite 1 Fax: (605) 367-5239

Sioux Falls, SD 57501 Email: DSSBHINDMED@state.sd.us

*Please allow up to 5 business days for this application to be processed. *

Non-Discrimination Statement

The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501, 605-773-3305.

***Español (Spanish) -** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800- 305-9673 (TTY: 711).*

***Deutsch (German) -** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).*