South Dakota Indigent Medication Program

Update-Extension Request Form

Applications will be processed within 5 business days after completed application is received.
Entire application must be completed.
Please print clearly.

Date:_____

Request:
☐ Update
☐ 1st Extension
☐ 2nd Extension
☐3rd Extension
***If there is continues to be a need after the 3rd extension, contact the Division of Behavioral Health at (605)367-5236.

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

Agency Name:_____

Email Address: _____

Applicant Information:
Applicant Name:_____

DOB:_____

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 Insurance)

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

If yes, what plan are you on? _____

If no, why not? _____

Financial Information:
Has your annual household income changed since being in this program? Yes☐ No☐ If yes, complete the following:

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)*

Alternative Funding Options *(required)*: Check all options you are pursuing.
☐ Prescription Assistance
☐ Insurance/Medicaid
☐ Self-Pay/Budgeting
☐ Medication Samples
☐ None – Why not?_____

Participating Pharmacy: Yes☐ No☐

Pharmacy: _____

Address: _____City/State/Zip: _____

Phone: _____ Fax (if known):_____

Medication	Dosage	Quantity per month	Reason for Extension	Co-pay amount

Participating Laboratory Services: Yes☐ No☐

Lab Center: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax (if known): _____

Lab Test	Reason for Extension

Return To:

Division of Behavioral Health
3900 W. Technology Drive, Suite 1
Sioux Falls, SD 57106

Phone: (605) 367-5236
Fax: (605) 367-5239
Email: DSSBHINDMED@state.sd.us

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).